

CERTIFICATE OF DEATH

Reg. Dist. No.

3519

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|---|----------------------------------|--|---|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY St. Marys MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY St. Marys | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leonardtwn | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hollywood | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION St. Marys Hospital | | | | e. STREET ADDRESS Rural | | | |
| 3. NAME OF DECEASED (Type or print) First Joseph Middle Claude Last Buckler | | | | 4. DATE OF DEATH Month March Day 11 Year 19 59 | | | |
| 5. SEX male | 6. COLOR OR RACE white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 12 / 28 / 1905 | | 9. AGE (In years last birthday) yrs. 53 | 10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter | | 10b. KIND OF BUSINESS OR INDUSTRY Construction | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Richard L. Buckler | | | | 14. MOTHER'S MAIDEN NAME Sadie V. Burroughs | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO. 219-05-3692 | | 17. INFORMANT Address Howard Buckler - Leonardtown, Md. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute haemorrhagic Pancreatitis DUE TO 322.2 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Acute cholecystitis (c) Alcoholism | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | 20g. (City or town) (County) (State) | | | |
| 21. I certify that I attended the deceased from 3-7 , 19 57 , to 3-11 , 19 59 , that I last saw the deceased alive on 3-11 , 19 59 , and that death occurred at 3:30 PM , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE David L. Mossman M.D. | | | | DATE SIGNED 3-11-59 | | | |
| PHYSICIAN'S NAME (Type) David L. Mossman MD | | | | Mechanicsville, Md. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 3/14/59 | | 22c. NAME OF CEMETERY OR CREMATORY St. Joseph | | 22d. LOCATION (City, town, or county) (State) Morganza, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE P.B. Robinson - Leonardtown, Md. | | | | 24a. REC'D BY REGISTRAR DATE MAR 19 59 | | 24b. REGISTRAR'S SIGNATURE Arthur S. Kraus | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03513

3520

CERTIFICATE OF DEATH

Reg. Dist. No.

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|---|------------------------------------|--|---|
| 1. PLACE OF DEATH a. COUNTY St. Mary's MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY St. Mary's | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Mechanicsville | | c. LENGTH OF STAY IN 1b Life | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) Dorothy Teresa Countiss | | 4. DATE OF DEATH March 2, 1959 | |
| 5. SEX Female | 6. COLOR OR RACE Colored | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Jan. 1, 1933 |
| 9. AGE (In years last birthday) 26 yrs | | 10. IF UNDER 1 YEAR Months Days Hours Min. | 11. IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House work | | 10b. KIND OF BUSINESS OR INDUSTRY Home | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Walter Countiss | | 14. MOTHER'S MAIDEN NAME Rachel Reed | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. None | |
| 17. INFORMANT Walter Countiss | | Address Mechanicsville, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Unknown 754.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Congenital heart disease - (patent since birth ductus arteriosus) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | INTERVAL BETWEEN ONSET AND DEATH Instant |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Jan 1, 1959 to Mar 2, 1959 , that I last saw the deceased alive on Feb 23, 1959 , and that death occurred at 10:30 M, from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Roy L. [Signature] | | ADDRESS (Street, city or town, state) DATE SIGNED Mechanicsville, Md. 3/3/59 | |
| PHYSICIAN'S NAME (Type) Mechanicsville, Maryland | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF 3/5/59 | 22c. NAME OF CEMETERY OR CREMATORY St. Joseph | 22d. LOCATION (City, town, or county) (State) Morganza, Md. |
| 23. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley | | ADDRESS Leonardtown, Md. | |
| 24a. REC'D BY REGISTRAR MAR 5 '59 | | 24b. REGISTRAR'S SIGNATURE Arthur E. [Signature] | |

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03514

3521

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | | | |
|--|---|---|---|---|---|
| 1. PLACE OF DEATH a. COUNTY St. Mary's MARYLAND | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY St. Mary's | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leonardtowntown | | c. LENGTH OF STAY IN 1b D.O.A. | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lexington Park X | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Mary's Hospital | | | d. STREET ADDRESS 305 Yorktown Road | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) Charles Franklin Deane | | | 4. DATE OF DEATH Month March Day 5 Year 1959 | | |
| 5. SEX male | 6. COLOR OR RACE white | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Jan. 18, 1877 | | 9. AGE (In years last birthday) 82 yrs. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Public Works | | 10b. KIND OF BUSINESS OR INDUSTRY Naval Air Sta. | | 11. BIRTHPLACE (State or foreign country) Virginia | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | 13. FATHER'S NAME William Jackson Deane | | |
| 14. MOTHER'S MAIDEN NAME Mary Buckley | | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | | |
| 16. SOCIAL SECURITY NO. | | | 17. INFORMANT Elizabeth Deane Address 305 York Town, Road | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary occlusion Conditions, if any, which gave rise to immediate cause (b) immed (c) 420.1 DUE TO Coronary occlusion gave rise to immediate cause (a), stating the underlying cause last. | | | | | INTERVAL BETWEEN ONSET AND DEATH immed |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour 19 a. m. p. m. | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | |
| ACTUAL SIGNATURE W.D. Boyd | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | DATE SIGNED 3/7/59 | |
| EXAMINER'S NAME (Type) William D. Boyd M.D. | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF 3/8/59 | 22c. NAME OF CEMETERY OR CREMATORY Stanardsville | | 22d. LOCATION (City, town, or county) (State) Stanardsville, Va. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley | | ADDRESS Leonardtowntown, Md. | | 24a. REC'D BY REGISTRAR DATE MAR 10 '59 | |
| | | | | 24b. REGISTRAR'S SIGNATURE Arthur S. Kline | |

WEST AND STATE DEPARTMENT OF HEALTH - BANGOR, ME
ATOMIC AND EXAMINING CERTIFICATE OF DENTIST

| | | | |
|------------------------|--|-----------------------|--|
| Name of Applicant | | Date of Birth | |
| Address | | City | |
| State | | County | |
| Education | | Experience | |
| References | | Remarks | |
| Signature of Applicant | | Signature of Examiner | |
| Date of Issuance | | Date of Expiration | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03515

CERTIFICATE OF DEATH

Reg. Dist. No.

3522

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|---|---|---|---|
| 1. PLACE OF DEATH a. COUNTY St. Mary's MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY St. Mary's | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leonardtwn | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural X Oakley | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION St. Mary's Hospital | | d. STREET ADDRESS 1 | |
| e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Grace Middle Blackistone Last Dent | | 4. DATE OF DEATH Month March Day 21 , Year 1959 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH June 1, 1865 |
| 9. AGE (In years and birthday) 93 yrs. 9 Months 20 Days 20 Hours Min. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife | |
| 10b. KIND OF BUSINESS OR INDUSTRY Home | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | |
| 13. FATHER'S NAME Z. D. Blackistone | | 14. MOTHER'S MAIDEN NAME Nannie Shanks | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 1 | |
| 17. INFORMANT Mazie D. Reaney | | Address Oakley, Maryland | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac decompensation 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic cardio-vascular disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 10 days 5 yrs. | | | INTERVAL BETWEEN ONSET AND DEATH 10 days 5 yrs. |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from March 19, 1954 to March 21, 1959 , that I last saw the deceased alive on 21 March, 1959 , and that death occurred at 7:30 AM , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Joseph E. Gill | | ADDRESS (Street, city or town, state) Leonardtwn, Md. | |
| PHYSICIAN'S NAME (Type) Joseph E. Gill M.D. | | DATE SIGNED 3/21/59 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 3/23/59 | |
| 22c. NAME OF CEMETERY OR CREMATORY All Saints | | 22d. LOCATION (City, town, or county) (State) Oakley, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley | | ADDRESS Leonardtwn, Md. | |
| 24a. REC'D BY REGISTRAR MAR 24 '59 | | 24b. REGISTRAR'S SIGNATURE Arthur S. Kline | |

CERTIFICATE OF DEATH

MASSACHUSETTS
DEPARTMENT OF HEALTH
BOSTON, MASS.

1. Name of deceased: _____
2. Sex: _____
3. Age: _____
4. Date of death: _____
5. Place of death: _____
6. Cause of death: _____
7. Signature of physician: _____
8. Signature of registrar: _____
9. Date of registration: _____

TO BE RETAINED BY THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03517

3523

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|---|----------------------------------|---|--|
| 1. PLACE OF DEATH a. COUNTY St. Mary's MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY St. Mary's | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leonardtwn | | c. LENGTH OF STAY IN 1b 6 weeks | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION St. Mary's Hospital | | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) William Gwinn Joy | | 4. DATE OF DEATH Month March Day 26 Year 19 59 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Nov. 14, 1871 |
| 9. AGE (In years last birthday) 87 yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming | | 10b. KIND OF BUSINESS OR INDUSTRY Farm | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Wallace Joy | | 14. MOTHER'S MAIDEN NAME Charlotte Hayden | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. None | |
| 17. INFORMANT Mrs Myres Dean | | Address Hollywood, Maryland | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart Failure 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized Atherosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 1 mo. 15 years | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Jan 1946 to Mch 26 1959 that I last saw the deceased alive on Mch 26 1959 , and that death occurred at 8:10 A.M. , from the causes and on the date stated above. | | DATE SIGNED 3-27-59 | |
| ACTUAL SIGNATURE W H Patrick M.D. Lexington Park, Md. | | ADDRESS (Street, city or town, state) | |
| PHYSICIAN'S NAME (Type) William H. Patrick M.D. | | Lexington Park, Maryland | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 3/28/59 | |
| 22c. NAME OF CEMETERY OR CREMATORY Joy Chapel | | 22d. LOCATION (City, town, or county) (State) Hollywood, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley | | ADDRESS Leonardtwn, Md. | |
| 24a. REC'D BY REGISTRAR DATE MAR 30 '59 | | 24b. REGISTRAR'S SIGNATURE Arthur S. Thomas | |

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3524

CERTIFICATE OF DEATH

Reg. Dist. No.

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|---|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY St. Marys MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY St. Marys | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) St. Inigoes | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) St. Inigoes | | | |
| c. LENGTH OF STAY IN TB life | | | | d. STREET ADDRESS Rural | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rural | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Glenn Middle William Last Owens | | | | 4. DATE OF DEATH Month 2 / Day 13 / Year 19 59 | | | |
| 5. SEX male | | 6. COLOR OR RACE white | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH June 15, 1955 | |
| 9. AGE (In years last birthday) 3 yrs. | | IF UNDER 1 YEAR Months 3 Days 13 Hours 19 Min. | | IF UNDER 24 HRS Months 3 Days 13 Hours 19 Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none | | | | 10b. KIND OF BUSINESS OR INDUSTRY ----- | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | | | | | | |
| 13. FATHER'S NAME Thomas W. Ownes | | | | 14. MOTHER'S MAIDEN NAME Mary Rita Carroll | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO. ----- | | 17. INFORMANT Thomas W. Ownes - St. Inigoes, Md. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a). Neuroblastoma 193.4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ----- DUE TO (c) ----- | | | | INTERVAL BETWEEN ONSET AND DEATH 7 mths | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 6-27-1955 to 3-13-1959 that I last saw the deceased alive on 3-13-59 , 19 59 , and that death occurred at 6:30 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Lexington Park, Md. DATE SIGNED 3/14/59 | | | | | | | |
| ACTUAL SIGNATURE Wm. H. Patrick M.D. | | | | PHYSICIAN'S NAME (Type) Wm. H. Patrick, MD | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | | 22b. DATE THEREOF 3/16/59 | | 22c. NAME OF CEMETERY OR CREMATORY St. Michaels | |
| 22d. LOCATION (City, town, or county) (State) Ridge, Md. | | | | | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE P.B. Robinson - Leonardtown, Md. | | | | 24a. REC'D BY REGISTRAR MAR 19 '59 | | 24b. REGISTRAR'S SIGNATURE Arthur S. Kline | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

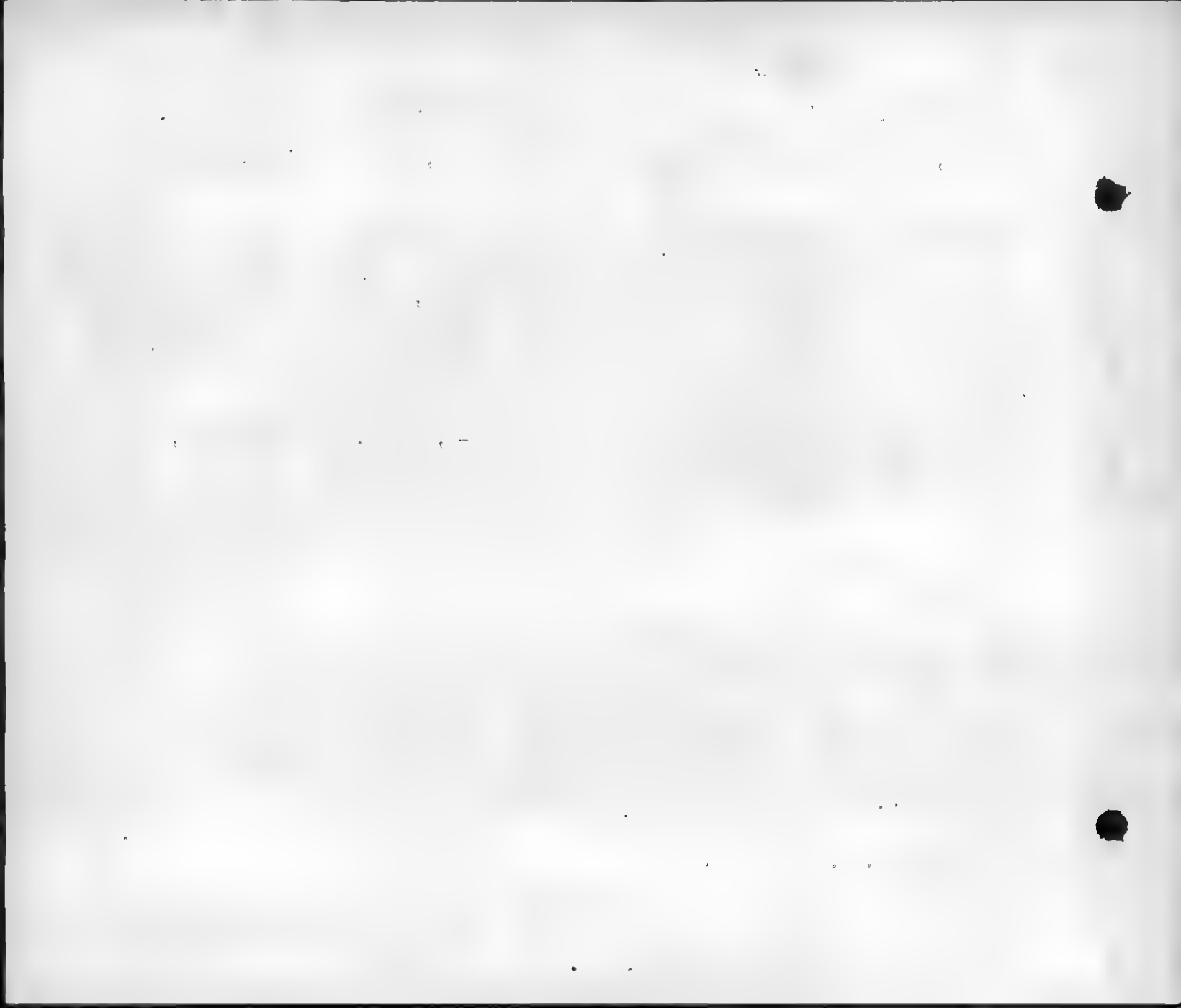
0351:1

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|--|--------------------------------------|---|---|
| 1. PLACE OF DEATH a. COUNTY St. Mary's MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admision) a. STATE Maryland b. COUNTY St. Mary's | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) USNAS, Patuxent River | | c. LENGTH OF STAY IN 1b 5 Weeks | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) | | d. STREET ADDRESS | |
| 3. NAME OF DECEASED (Type or print) Stephen Wade Phillips | | 4. DATE OF DEATH Month March Day 1 Year 1959 | |
| 5. SEX Male | 6. COLOR OR RACE Caucasian | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH January 20, 1959 |
| 9. AGE (In years last birthday) yrs 1 Months 9 Days 9 | | 10. IF UNDER 1 YEAR Months 9 Days 9 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Regnald Wade Phillips | | 14. MOTHER'S MAIDEN NAME Eunice Rose Caskey | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT MEMQ 757-A, USNAS, Patuxent River, Maryland | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Diagnosis Pending Autopsy (Probable Pneumonia) 411X DUE TO Pneumonia, lobular Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hepatomegaly (235 g.) INTERVAL BETWEEN ONSET AND DEATH 72 hours | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour 19 p. m. | | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> J. EDMONDS, LT MC USNR, USNAS, Patuxent River, Maryland ACTUAL SIGNATURE Wm. D. Boyd CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. EXAMINER'S NAME (Type) Wm. D. BOYD, M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 3/1/59 | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Removal | | 22b. DATE THEREOF 3/2/59 | |
| 22c. NAME OF CEMETERY OR CREMATORY | | 22d. LOCATION (City, town, or county) (State) Belmont, North Carolina | |
| 23. FUNERAL DIRECTOR'S SIGNATURE P.B. Robinson - Leonardtown, Md. | | 24a. REC'D BY REGISTRAR MAR 4 '59 | |
| 24b. REGISTRAR'S SIGNATURE Arthur L. Kraus | | | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained by your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03520

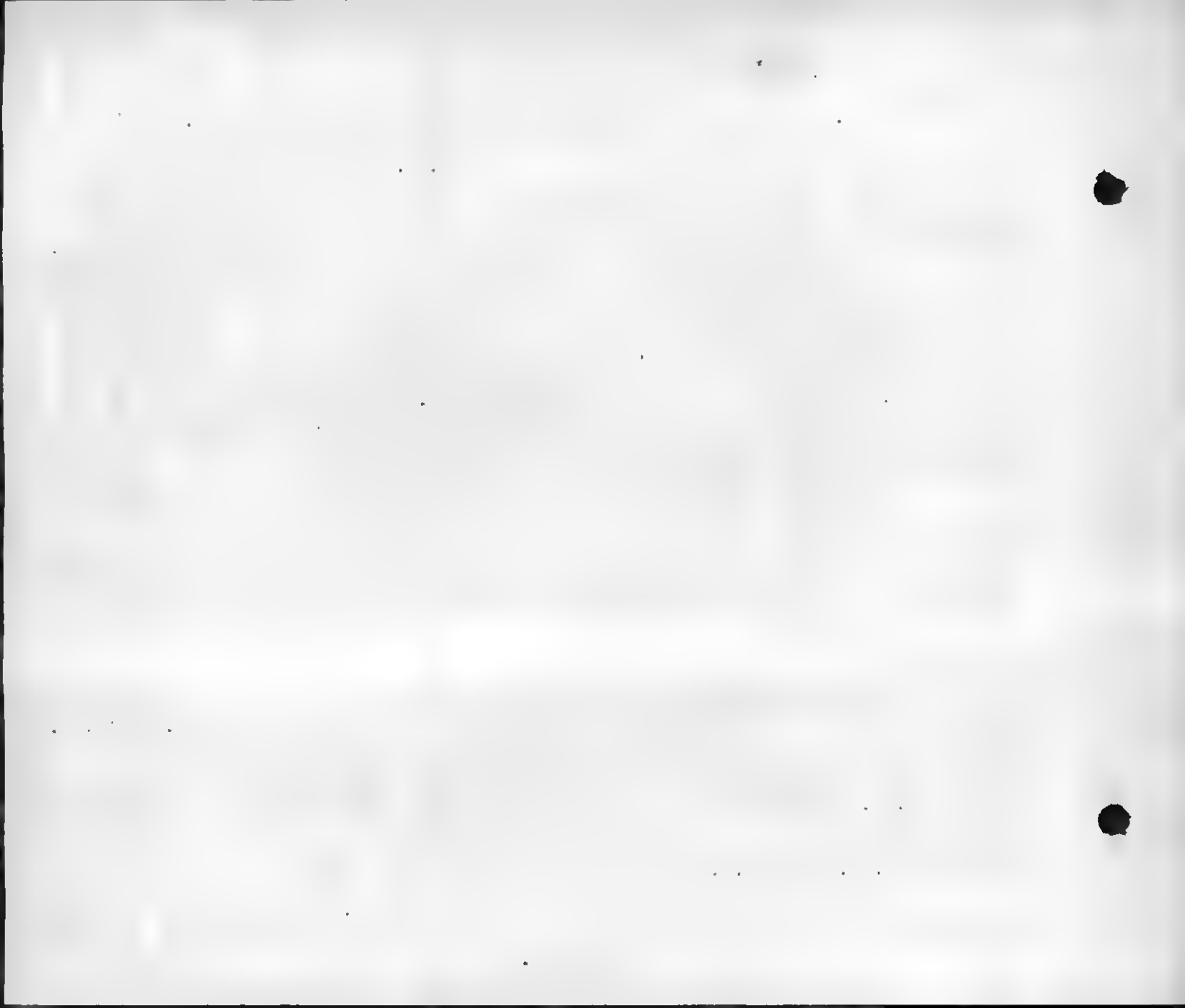
3526

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | |
|---|--|--|---|
| 1. PLACE OF DEATH a. COUNTY St. Mary's MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY St. Mary's | |
| b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) Lexington Park | | c. LENGTH OF STAY IN 1b 2 yr | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Gateway Tavern | | e. STREET ADDRESS Patuxent River, Maryland U. S. Naval Air Station | |
| 3. NAME OF DECEASED (Type or print) First Marion Leon Middle SHARPE Last SHARPE | | 4. DATE OF DEATH Month March Day 14 Year 19 59 | |
| 5. SEX Male | 6. COLOR OR RACE Caucasian | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH 21 March 1926 |
| 9. AGE (in years last birthday) 32 yrs | | 10. IF UNDER 1 YEAR Months 14 Days 19 Hours 59 Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electronics Technician | | 10b. KIND OF BUSINESS OR INDUSTRY U. S. Navy | |
| 11. BIRTHPLACE (State or foreign country) South Carolina | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Langford C. SHARPE | | 14. MOTHER'S MAIDEN NAME Kittie B. (last name not available) | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Yes 10-48 to 3-59 | | 16. SOCIAL SECURITY NO 248 34 6418 | |
| 17. INFORMANT Official U. S. Navy Records, USNAS, Patuxent River, Maryland | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) BURNS, 3RD Degree, 95% of body area 916.6 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) 916.6 DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Acute Alcoholism | | | INTERVAL BETWEEN ONSET AND DEATH Minutes |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Found in flaming building | |
| 20c. TIME OF INJURY Month, Day, Year 10:50 a.m. 14 Mar 19 59 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, off ice bldg., etc.) Tavern | 20f. (City or town) (County) (State) Lexington Park, St. Mary's, Md. |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Marion Leon Sharpe Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> I. B. KORETSKY, LT MC USNR, USNAS, Patuxent River, Maryland 16 March 1959 ACTUAL SIGNATURE I. B. Koretsky M.D. CHIEF MEDICAL EXAMINER EXAMINER'S NAME (Type) WM. D. BOYD, M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Transportation 3/17/59 | 22b. DATE THEREOF 3/17/59 | 22c. NAME OF CEMETERY OR CREMATORY Winnsboro, South Carolina | 22d. LOCATION (City, town, or county) (State) Winnsboro, South Carolina |
| 23. FUNERAL DIRECTOR'S SIGNATURE P.B. Robinson - Leonardtown, Md. | | 24a. REC'D BY REGISTRAR DATE MAR 19 59 | 24b. REGISTRAR'S SIGNATURE Arthur S. Kline |



FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03521

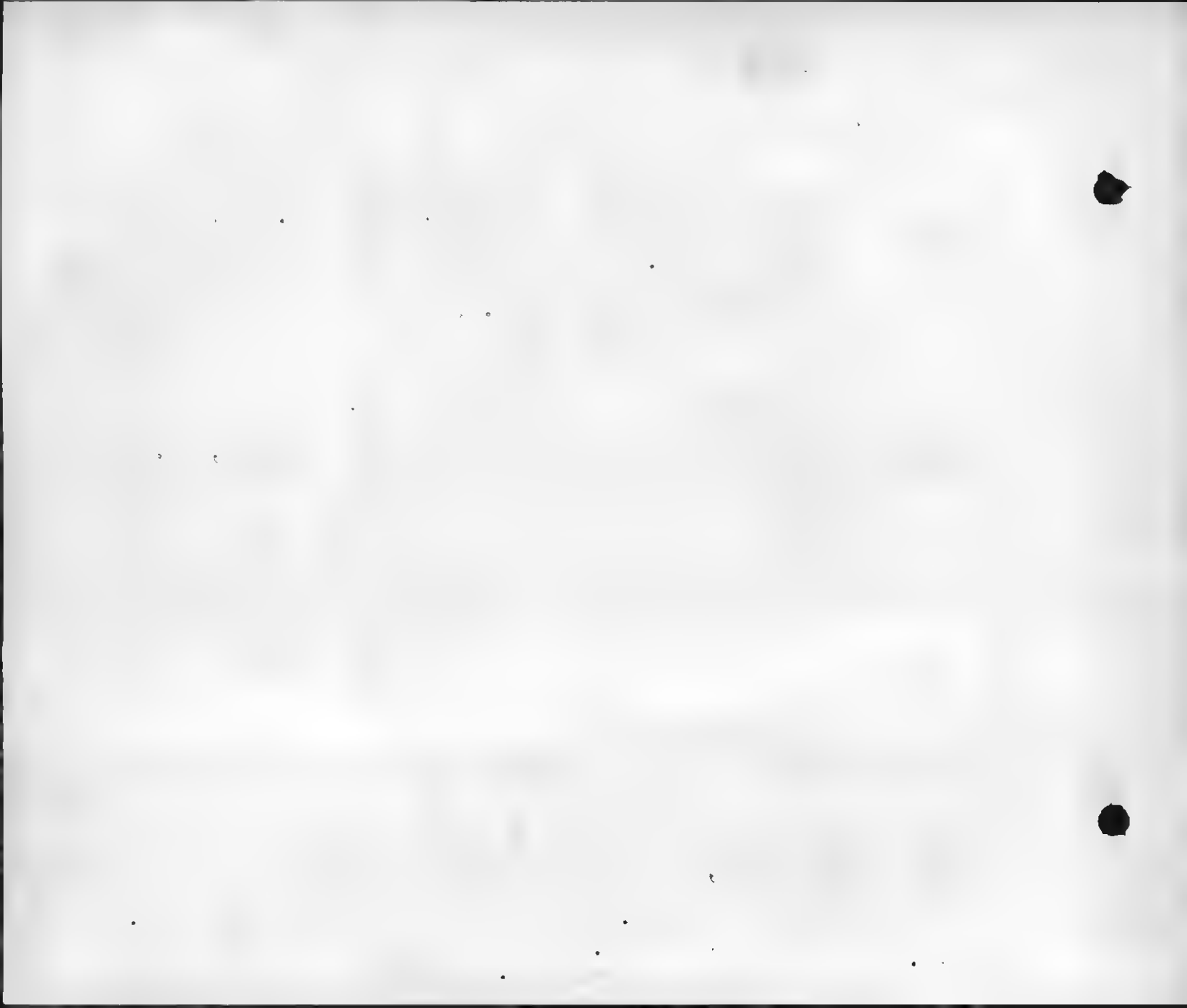
3527

Item 1 Film 6241 4-6-59 et

Reg. Dist. No.

| | | | |
|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY St. Marys MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE District of Columbia | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ridge | | c. LENGTH OF STAY IN 1b 5 mo. | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Rural Private home | | d. STREET ADDRESS 1505 Swann St. N.W. | |
| 3. NAME OF DECEASED (Type or print) Agnes I. Taylor | | 4. DATE OF DEATH Month March Day 23 Year 1959 | |
| 5. SEX female | 6. COLOR OR RACE colored | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Nov. 9, 1875 |
| 9. AGE (in years last birthday) 83 yrs | | 10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maid | | 10b. KIND OF BUSINESS OR INDUSTRY Domestic | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY USA | |
| 13. FATHER'S NAME Charles Taylor | | 14. MOTHER'S MAIDEN NAME Sophie Gough | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) no | | 16. SOCIAL SECURITY NO. ---- | |
| 17. INFORMANT Annie E. Barnes - Ridge, Md. | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Coronary Occlusion DUE TO (b) Immobil Conditions, if any, which gave rise to immediate cause (c) ----- DUE TO (c) ----- PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ----- (b) ----- (c) ----- | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month 19 Day 19 Hour 0 a. m. 0 p. m. | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE Wm. D. Boyd | | DATE SIGNED 3/23/59 | |
| EXAMINER'S NAME (Type) Wm. D. Boyd, MD | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| 22a. BURIAL CREMATION REMOVAL (Specify) Burial | 22b. DATE THEREOF 3/25/59 | 22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet | 22d. LOCATION (City, town, or county) (State) Washington, D.C. |
| 23. FUNERAL DIRECTOR'S SIGNATURE Robt. G. McGuire | | 24a. REC'D BY REGISTRAR 31 MAR '59 | |
| 24b. REGISTRAR'S SIGNATURE Arthur S. Kline | | 24c. REGISTRAR'S SIGNATURE | |

TO DUTY MEDICAL EXAMINER: This certificate shall be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03522

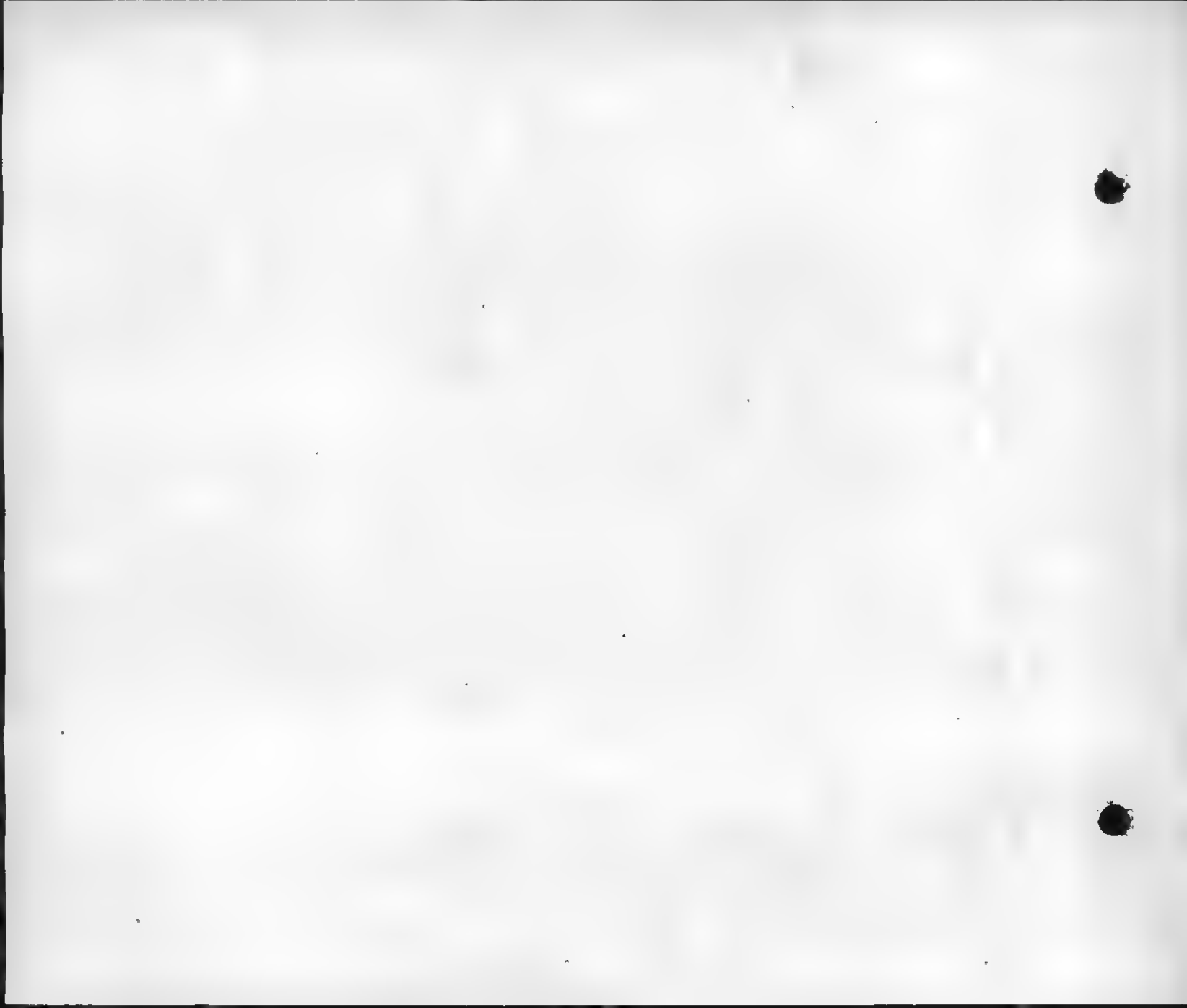
FOR STATE
HEALTH DEPT.

3528

Reg. Dist. No.

| | | | |
|--|----------------------------------|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>St. Mary's</u> <u>MARYLAND</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>St. Mary's</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>State Route 242 Morganza</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Chaptico</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) | | d. STREET ADDRESS | |
| 3. NAME OF DECEASED (Type or print) <u>Samuel Edward Vallandingham</u> | | 4. DATE OF DEATH Month <u>March</u> Day <u>6</u> Year <u>1959</u> | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Feb. 16, 1918</u> |
| 9. AGE (In years, last birthday) <u>41</u> yrs | | 10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Tenant</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>William L. Vallandingham</u> | | 14. MOTHER'S MAIDEN NAME <u>Bessie M. Quade</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>214 12 7290</u> | |
| 17. INFORMANT <u>Bessie M. Vallandingham</u> | | Address <u>Chaptico, Md.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Multiple Crushing Injuries</u> <u>812x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). <u>Broken neck, fracture Both legs, fracture hip</u> | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>Pushing car down road, Another car ran up from behind</u> | |
| 20c. TIME OF INJURY Month, Day, Year <u>7:15 p.m. 3/6 1959</u> | | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office, shop, etc.) <u>State road 242</u> | | 20f. (City or town) (County) (State) <u>Morganza, St. Mary's Md.</u> | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE <u>William D. Boyd</u> | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| EXAMINER'S NAME (Type) <u>William D. Boyd M.D.</u> | | DATE SIGNED <u>3/6/59</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>3/10/59</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Sacred Heart</u> | | 22d. LOCATION (City, town, or county) (State) <u>Bushwood, Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>W. Clarke Mattingley</u> | | ADDRESS <u>Leonardtwn, Md.</u> | |
| 24a. REC'D BY REGISTRAR <u>Arthur S. Kline</u> | | DATE <u>MAR 10 '59</u> | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be given to the Chief Medical Examiner's Office along with form PM-2. Page 5 may be retained by your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 Items 1, 5 Film 6240 3-24-59 et
3529
CERTIFICATE OF DEATH

03523

Reg. Dist. No.

| | | | | | | | |
|---|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY St. Mary's MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY St. Mary's | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) St. George Island | | | | c. LENGTH OF STAY IN 1b 9 weeks | | | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rural Morganza | | | | d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Private home | | | |
| d. STREET ADDRESS 1 | | | | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Ester Middle Woodburn Last Woodburn | | | | 4. DATE OF DEATH Month March Day 16 Year 19 59 | | | |
| 5. SEX Female | | 6. COLOR OR RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH Feb. 5, 1888 1873 | |
| 9. AGE (In years lost birthday) yrs. 86 | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farm Owner | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Richard Woodburn | | | | 14. MOTHER'S MAIDEN NAME Sarah Burroughs | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) — | | | | 16. SOCIAL SECURITY NO. — | | | |
| 17. INFORMANT J.J. Johnson | | | | Address Bushwood, Maryland | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized arteriosclerosis 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) | | | | | | INTERVAL BETWEEN ONSET AND DEATH 10 years | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) | | | | 20g. (County) | | 20h. (State) | |
| 21. I certify that I attended the deceased from Feb 15, 1959 to March 16, 1959 , that I last saw the deceased alive on March 14, 1959 , and that death occurred at 2 A. M. from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE [Signature] | | | | ADDRESS (Street, city or town, state) [Address] | | | |
| PHYSICIAN'S NAME (Type) [Name] | | | | DATE SIGNED 3/16/59 | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 3/18/59 | | 22c. NAME OF CEMETERY OR CREMATORY St. Joseph | | 22d. LOCATION (City, town, or county) (State) Morganza, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley Leonardtown, Md. | | | | 24a. REC'D BY REGISTRAR DATE MAR 18 '59 | | 24b. REGISTRAR'S SIGNATURE [Signature] | |

CERTIFICATE OF DEATH

1950

| | | | | | | | | | |
|------------------------|--|------------------------|--|------------------------|--|-----------------------------|--|---------------------------|--|
| Name of Deceased | | Sex | | Age | | Date of Birth | | Place of Birth | |
| John Doe | | Male | | 45 | | Jan 15, 1905 | | Baltimore, Md. | |
| Occupation | | Cause of Death | | Date of Death | | Place of Death | | Time of Death | |
| Teacher | | Heart Disease | | Jan 20, 1950 | | Home | | 10:00 AM | |
| Signature of Physician | | Signature of Registrar | | Signature of Informant | | Signature of Burial Officer | | Signature of Funeral Home | |
| [Signature] | | [Signature] | | [Signature] | | [Signature] | | [Signature] | |
| Date of Report | | Date of Entry | | Date of Filing | | Date of Publication | | Date of Distribution | |
| Jan 25, 1950 | | Jan 25, 1950 | | Jan 25, 1950 | | Jan 25, 1950 | | Jan 25, 1950 | |

14-10000-1-50

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
3530 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03524

Reg. Dist. No.

| | | | |
|--|--|---|---|
| 1. PLACE OF DEATH a. COUNTY St. Marys' MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY St. Marys' | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Patuxent River | | c. LENGTH OF STAY IN 1b 3 yrs. | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Parking lot across from Bldg. #306 | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First RAYMOND Middle CHARLEY Last WRIGHT | | 4. DATE OF DEATH Month March Day 30 Year 19 59 | |
| 5. SEX Male | 6. COLOR OR RACE Caucasian | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 28 May 1918 |
| 9. AGE (In years last birthday) 40 yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Aviation Mechanic | 11. BIRTHPLACE (State or foreign country) Arkansas |
| 10b. KIND OF BUSINESS OR INDUSTRY U.S. Navy | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME William M. WRIGHT | | 14. MOTHER'S MAIDEN NAME Mary J. | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Yes 7/43 to 3/59 | | 16. SOCIAL SECURITY NO. 548 07 9218 | |
| 17. INFORMANT Naval Service Record | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) WOUND, Missile, Nasal-pharynx & Brain, Gunshot DUE TO Artery & Nerve Involvement Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ | | | INTERVAL BETWEEN ONSET AND DEATH Minutes |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Apparent self inflicted gunshot wound | |
| 20c. TIME OF INJURY Month, Day, Year 0530 a.m. March 30 1959 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Parking lot | 20f. (City or town) (County) (State) Patuxent River, St. Marys, Md. |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE J. J. King EXAMINER'S NAME (Type) WM. D. BOYD, M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 4/6/59 | |
| 22c. NAME OF CEMETERY OR CREMATORY Arlington National | | 22d. LOCATION (City, town, or county) (State) Arlington, Va. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE P.B. Robinson - Leonardtown, Md. | | 24a. REC'D BY REGISTRAR DATE APR 7 '59 | |
| | | 24b. REGISTRAR'S SIGNATURE Arthur S. Kraus | |

ADDITIONAL INFORMATION: TAMILNADU STATE GOVT
HQA NO. 174/2005-2006/2007/2008/2009/2010/2011/2012/2013/2014/2015/2016/2017/2018/2019/2020/2021/2022/2023/2024/2025/2026/2027/2028/2029/2030/2031/2032/2033/2034/2035/2036/2037/2038/2039/2040/2041/2042/2043/2044/2045/2046/2047/2048/2049/2050/2051/2052/2053/2054/2055/2056/2057/2058/2059/2060/2061/2062/2063/2064/2065/2066/2067/2068/2069/2070/2071/2072/2073/2074/2075/2076/2077/2078/2079/2080/2081/2082/2083/2084/2085/2086/2087/2088/2089/2090/2091/2092/2093/2094/2095/2096/2097/2098/2099/2100/2101/2102/2103/2104/2105/2106/2107/2108/2109/2110/2111/2112/2113/2114/2115/2116/2117/2118/2119/2120/2121/2122/2123/2124/2125/2126/2127/2128/2129/2130/2131/2132/2133/2134/2135/2136/2137/2138/2139/2140/2141/2142/2143/2144/2145/2146/2147/2148/2149/2150/2151/2152/2153/2154/2155/2156/2157/2158/2159/2160/2161/2162/2163/2164/2165/2166/2167/2168/2169/2170/2171/2172/2173/2174/2175/2176/2177/2178/2179/2180/2181/2182/2183/2184/2185/2186/2187/2188/2189/2190/2191/2192/2193/2194/2195/2196/2197/2198/2199/2200/2201/2202/2203/2204/2205/2206/2207/2208/2209/2210/2211/2212/2213/2214/2215/2216/2217/2218/2219/2220/2221/2222/2223/2224/2225/2226/2227/2228/2229/2230/2231/2232/2233/2234/2235/2236/2237/2238/2239/2240/2241/2242/2243/2244/2245/2246/2247/2248/2249/2250/2251/2252/2253/2254/2255/2256/2257/2258/2259/2260/2261/2262/2263/2264/2265/2266/2267/2268/2269/2270/2271/2272/2273/2274/2275/2276/2277/2278/2279/2280/2281/2282/2283/2284/2285/2286/2287/2288/2289/2290/2291/2292/2293/2294/2295/2296/2297/2298/2299/2300/2301/2302/2303/2304/2305/2306/2307/2308/2309/2310/2311/2312/2313/2314/2315/2316/2317/2318/2319/2320/2321/2322/2323/2324/2325/2326/2327/2328/2329/2330/2331/2332/2333/2334/2335/2336/2337/2338/2339/2340/2341/2342/2343/2344/2345/2346/2347/2348/2349/2350/2351/2352/2353/2354/2355/2356/2357/2358/2359/2360/2361/2362/2363/2364/2365/2366/2367/2368/2369/2370/2371/2372/2373/2374/2375/2376/2377/2378/2379/2380/2381/2382/2383/2384/2385/2386/2387/2388/2389/2390/2391/2392/2393/2394/2395/2396/2397/2398/2399/2400/2401/2402/2403/2404/2405/2406/2407/2408/2409/2410/2411/2412/2413/2414/2415/2416/2417/2418/2419/2420/2421/2422/2423/2424/2425/2426/2427/2428/2429/2430/2431/2432/2433/2434/2435/2436/2437/2438/2439/2440/2441/2442/2443/2444/2445/2446/2447/2448/2449/2450/2451/2452/2453/2454/2455/2456/2457/2458/2459/2460/2461/2462/2463/2464/2465/2466/2467/2468/2469/2470/2471/2472/2473/2474/2475/2476/2477/2478/2479/2480/2481/2482/2483/2484/2485/2486/2487/2488/2489/2490/2491/2492/2493/2494/2495/2496/2497/2498/2499/2500/2501/2502/2503/2504/2505/2506/2507/2508/2509/2510/2511/2512/2513/2514/2515/2516/2517/2518/2519/2520/2521/2522/2523/2524/2525/2526/2527/2528/2529/2530/2531/2532/2533/2534/2535/2536/2537/2538/2539/2540/2541/2542/2543/2544/2545/2546/2547/2548/2549/2550/2551/2552/2553/2554/2555/2556/2557/2558/2559/2560/2561/2562/2563/2564/2565/2566/2567/2568/2569/2570/2571/2572/2573/2574/2575/2576/2577/2578/2579/2580/2581/2582/2583/2584/2585/2586/2587/2588/2589/2590/2591/2592/2593/2594/2595/2596/2597/2598/2599/2600/2601/2602/2603/2604/2605/2606/2607/2608/2609/2610/2611/2612/2613/2614/2615/2616/2617/2618/2619/2620/2621/2622/2623/2624/2625/2626/2627/2628/2629/2630/2631/2632/2633/2634/2635/2636/2637/2638/2639/2640/2641/2642/2643/2644/2645/2646/2647/2648/2649/2650/2651/2652/2653/2654/2655/2656/2657/2658/2659/2660/2661/2662/2663/2664/2665/2666/2667/2668/2669/2670/2671/2672/2673/2674/2675/2676/2677/2678/2679/2680/2681/2682/2683/2684/2685/2686/2687/2688/2689/2690/2691/2692/2693/2694/2695/2696/2697/2698/2699/2700/2701/2702/2703/2704/2705/2706/2707/2708/2709/2710/2711/2712/2713/2714/2715/2716/2717/2718/2719/2720/2721/2722/2723/2724/2725/2726/2727/2728/2729/2730/2731/2732/2733/2734/2735/2736/2737/2738/2739/2740/2741/2742/2743/2744/2745/2746/2747/2748/2749/2750/2751/2752/2753/2754/2755/2756/2757/2758/2759/2760/2761/2762/2763/2764/2765/2766/2767/2768/2769/2770/2771/2772/2773/2774/2775/2776/2777/2778/2779/2780/2781/2782/2783/2784/2785/2786/2787/2788/2789/2790/2791/2792/2793/2794/2795/2796/2797/2798/2799/2800/2801/2802/2803/2804/2805/2806/2807/2808/2809/2810/2811/2812/2813/2814/2815/2816/2817/2818/

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